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## AMERICAN SCHOOL HEALTH ASSOCIATION

*Organized* 1927

*Devoted to the interests and advancement of those engaged in school health activities and the service rendered by them*

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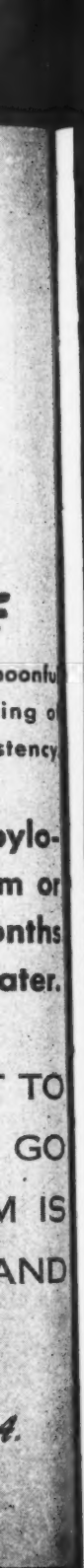

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THE JOURNAL OF SCHOOL HEALTH

*Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.*

Vol. XVIII JUNE, 1948 No. 6

## HEAD ON !*

DOCTORS HARRY E. MOCK, HARRY E. MOCK, JR., AND CHARLES J. MOCK

*This is part two of a two part article by the Doctors Mock*

**"Mystery Death" in Football Players,**—According to H. V. Porter, executive secretary of State High School Athletic associations, many of the football players who have died were, apparently, only slightly injured, often showing no injury about the head; yet several hours later they complained of dizziness or of severe headaches—or suddenly became unconscious and died within a few minutes to a few hours. The cause of death, as given by the doctor or coroner, was usually "cerebral hemorrhage." He stated that in football parlance these deaths were often referred to as "mystery deaths."

A summary of a few of these deaths among high school football players during the 1946 season illustrates what is meant by "mystery deaths":

1. "J. T., injured in a six-man practice game. The boy tackled an opponent and, in the next huddle, complained of feeling dizzy. He was walked to the sidelines and collapsed at the bench. He did not regain consciousness. Death was due to 'cerebral hemorrhage.' There were no marks on head or body."
2. "L. J., 15 years old and a freshman, tackled an opponent rather high. It was assumed that he hit his head on his opponent's knee or heel. Helmet in good condition. Cause of death 'compound fracture and brain hemorrhage.' The nature of the hemorrhage suggested the possibility of an earlier injury aggravated by the final injury."
3. "W. S., injured during a line charge while playing defensive tackle. He remained on the sideline and accompanied the team to the dressing room after the game and then drove seven miles to his home, ate a heavy meal and afterwards complained of a headache. During the night he suddenly became unconscious and died. Cause of death 'cerebral hemorrhage.'"
4. "H. F., 17, was carrying a ball and was tackled. He met his opponent head-on. The boy's equipment was in good condition. Cause of death 'brain injury.'"

*Continued from May Journal.

In order to show the value of more explicit information concerning these deaths, we corresponded with the surgeon who attended this patient. From him it was ascertained that H. F., while playing football the year before, had a head injury and was unconscious for a short period. It was thought then that he had a small cerebral hemorrhage, but in several days he recovered perfectly. The final injury followed a very hard tackle. He was unconscious on the football field and was taken directly to a hospital (how he was carried from the field and how he was transported to the hospital was not stated).

**No Evidence,**—"There was no evidence of skull fracture as shown by the X-ray films. There was no autopsy done, but Dr. Herman, the neurological surgeon from Oklahoma City, explored by open operation and found a branch of the meningeal artery was ruptured" (extradural). "There was considerable blood below the dura" (subdural).

This case raises the question of whether any player who has sustained a severe head injury should ever be allowed to play football again.

5. "J. C., a 17-year-old senior, was six feet in height and weighed 180 pounds. During practice scrimmage he was carrying the ball when he was tackled, and since he was slow in getting up, the coach examined him to see if he had been hurt. The boy indicated he was not hurt, but after practice sessions he complained of being ill. While being taken to the hospital, two and one-half hours after practice, he died. There were no skull fractures and no marks or blows. Equipment was in good condition. Cause of death was given as 'cerebral hemorrhage'."

Here a trained physician, more interested in the players than in the game, would have recognized the potential danger in this injury and would have placed the boy under immediate observation, certainly before death occurred. If there were focal signs indicating the location of the hemorrhage, most probably extradural or subdural, an immediate operation might have saved him.

**Injured in Practice,**—6. "J. J., a senior, was injured in a practice scrimmage, September 25. In an off tackle play he tackled an opponent. He acted as if the wind were knocked out of him. He continued to watch the remainder of the scrimmage from the bench. The injury did not appear to be serious and he walked off the field and drove home. During the evening he was visiting a girl friend when he developed a fainting spell. Four days later he was taken to the hospital where an operation showed the kidney had been

punctured in two spots. The X-ray did not show any rib fracture. During the operation the kidney was removed. The boy died on September 30th."

While this is not a head injury case, yet in our practice we have seen many associated internal injuries overlooked because the surgeon's attention was directed completely to the head injury. The signs of internal injury are frequently disguised by the unconsciousness and other symptoms of head injury. Further, this case illustrates the lack of adequate medical attention even four days following this boy's injury. It would seem that any enlightened school would have followed up such a case and would have secured adequate surgical attention before it was too late to be of help.

**No Mystery,**—To the surgeon there is no mystery connected with these "mystery deaths." Education of the coaches, of all connected with the athletic departments, of the school authorities and of the players and parents, should go far to remove the mystery of such deaths from their minds.

From the standpoint of educating the layman concerning the mystery of these deaths and concerning some of the common fears associated with brain injuries, we wish to emphasize some of the facts and common sense principles which have played such a material part in the reduction of brain injury mortality rates.

The heroic spectacle of a dazed or knocked out player being half dragged, half walked from the field to a blanket at the sidelines, and later being clumsily carried by fellow players to the locker room, has thrilled the cheering audience but has done irreparable damage to certain of these victims. Only within the last two or three years have stretchers and trained stretcher bearers been seen at football games, and then only in a very few instances.

**Ambulance Service,**—Transporting players to the hospital in an ambulance has not been as convenient as transporting them in the nearby automobile and, furthermore, stretchers and ambulances give the game a bad name. The need for expert stretcher and ambulance service for a seriously injured football player is apparent.

The X-ray was discovered just before the turn of the century. Its ability to show a skull fracture was lauded by surgeons as a great advance, in 1896, when the first skull fracture was demonstrated by X-ray in Philadelphia. Thereafter, a serious head injury, regardless of the condition of the patient, was immediately X-rayed.

Many hospitals have placed their X-ray departments next to

the emergency admission room in order that an X-ray might be made before the patient was put to bed and treatment started. When the X-ray showed a depressed skull fracture or a bursting type of fracture, immediate operation seemed indicated and was advocated by many a good surgeon. Surgery within the first few hours after admission became the vogue.

**Common Sense Needed,**—Operations on skull fracture-brain injuries mounted to 25 and 30 per cent in 1900 to 1910. Today less than 10 per cent of these injuries are operated. It is now apparent that common-sense measures directed toward preserving the patient's life is far more important than early X-ray and operation.

Many an early X-ray today is made because the victim's relatives, an insurance company, or a lawyer demands "What does the X-ray show?" "Is a skull fracture present?"

In studying the records of the deaths of football players, it was found that an X-ray usually had been made of patients who died within the first 25 hours after the injury. Walking or half carried to the sidelines from the field, later walking to the dressing room, driving home, collapsing and being taken to the hospital, there being moved and turned in four directions to secure an X-ray, all before the patient died, bespeak neglect of the common-sense measures which have played such a big part in reducing brain injury mortality rates.

**Early Signs,**—No coach can be trained to recognize the early signs of a serious brain injury. Every practice scrimmage and every game carries the potential danger of a brain injury to some player. To prevent these "mystery deaths" a trained physician should be present.

In a few instances, early operation is absolutely life saving, but these instances are very rare, and the experienced physician will know when operation is indicated and will see that it is expertly performed.

**Emphasize Points,**—Applying all we have said to football players and to the administrative staffs of football organizations, the following points must now be emphasized:

1. Any head injury that causes a victim to have momentary unconsciousness, to be dazed or mentally disturbed, or to have any other type of disturbed consciousness, is sufficiently serious to warrant immediate examination by a physician and continued close observation, preferably in a hospital, until satisfied that no serious brain injury occurred.

2. An average of nine football players died each year since

1931 from skull fracture-brain injury conditions. If football is to continue to be played, even this small number warrants the presence or availability of a physician at every football game—practice or otherwise.

3. Public opinion must be aroused, not necessarily against the game, but against the schools that fail to provide every facility for the preservation of life of every injured football player, as well as for the prevention of any permanent disabilities from such injuries.

4. Given the presence of a physician at every game, this same public opinion will prevent the physician from treating casually every "knocked out" player. The physician will hesitate to say "The wind was just knocked out of him."

5. Stretchers must be made available for every football game. A slight subdural or extradural hemorrhage occurring away from the vital centers may stop oozing and may never cause any threat of life if the patient is immediately placed in a recumbent position and further exertion, such as walking or being dragged from the field, driven home in an automobile, unduly moved for X-rays, or otherwise carelessly handled, is prevented. Many a small vertebral fracture or partial dislocation of the neck may never cause any serious damage to the cord, if the patient is kept quiet from the first instant of injury.

The above mentioned exertions of careless handling can make the fracture worse or further dislocate the vertebra, which is chiefly responsible for the subsequently damaged cord and complete paralysis that may cause a life of helplessness even worse than death. The small tears or punctures of organs in the so-called internal injuries may subside if the patient is kept absolutely quiet, whereas exertion may cause continued and fatal hemorrhage from these injuries.

6. Absolute rest in bed, avoidance of damage by further exertions and close observation by a trained physician will reduce not only these "mystery deaths" to a minimum but will prevent many a permanent disability.

The dearth of statistics based upon a careful analysis of facts relative to every death from football is appalling. Co-operation between medicine, safety first engineers and educators in assembling every necessary fact is needed to make a real nationwide fight against the hazards of the game.

Speaking from the standpoint of medicine, every football fatality should be followed by a careful autopsy with a very detailed report of the site and exact nature of the injury. Such gen-

eral statements as "cerebral hemorrhage," "spinal injury," or "internal injury" are not sufficiently informative as to aid in a prevention fight.

If, in the case of head injury, autopsy reports should reveal that most of the cerebral hemorrhages were at the base of the brain, involving perhaps the numerous blood vessels making up the circle of Willis, then the vulnerable spot in each player would be the base of the skull where it joins that of the spinal column. Further study might reveal that the present hard, plastic headgear is the activating force at this vulnerable spot or enhances the danger of injury by *contrecoup*—the force waves centering at a spot in the skull or brain directly opposite the site of the blow.

The pathology responsible for deaths, as revealed by these autopsies, combined with a careful analysis of the type of equipment, the nature of the play that caused the accident, the condition of the player at the time of injury, his immediate care on the field, his transportation from the field, whether taken home or to a hospital, and the adequacy of the medical or surgical treatment rendered, all would furnish the basis for study of methods of prevention of football fatalities. —Reprinted from *Safety Education* of February 1948, p. 6.

* * * * *

## NOTICE

Committee Reports:

It has been the custom in many cases for Committees of the Association to present their reports to the Governing Council at the time of the annual meeting of the Association. This is not a desirable procedure since no time is given the Council for consideration of the report, either as to format or content. As these reports often involve some policy of the Association, not less than thirty days should be given the Council, or at least the Executive Committee of the Council, for consideration before the report is adopted by the Council. Failing such advance presentation, it would seem that the only sensible action of the Council would be to "Receive the report, and place it on file, or for further study by the Governing Council".

For the present, the Executive Committee feels strongly that at least a preliminary report should be in their hands thirty days before the first day of the annual meeting of the Governing Council.

The Association should not be made responsible for the content of a report unless the Council, or at least its Executive Committee has had a chance to study it. Only after such study should a report be "adopted".—*C.H.K.*

## ADOLESCENT GROWTH

GLADYS PATRIC SHAHOVITCH, M.D.

The babe in his helplessness has always made an understanding appeal for protection and help. We place a hand and arm under his head and back with a deep sense of our responsibility and his need. We watch for each tooth, for each developing emotion, patiently help him with his first step. By his third year he is running around, an individual who can look after many of his own problems. But still we guard him tenderly.

Later the child will have another period of rapid growth. This will occur during the years, approximately, from twelve to fifteen, or the junior high school age. He will not only be making a rapid growth outwardly but new and strange emotions will be developing within. He will need sympathy, patience, and consideration. Too frequently we look at his physical growth and expect the judgment of an adult.

In order to visualize the growth and developmental changes during these years, the physical education teachers of Nightingale Junior High worked out an interesting study on the growth and changes during the years spent at Nightingale.

The entering B7 boys and the graduating A9 boys are measured for standing height, chest girth, and weight. Many other measurements might have been taken but the aim was to have the students participate and these simple measurements could be done by the student under the supervision of an instructor.

The following figures were found to be the average on 54 B7 boys and 58 A9 boys:

| | *B7* | *A9* | |
|---|---|---|---|
| Standing height | 60.85 | 66.9 | inches |
| Sitting height | 30.41 | 32.2 | inches |
| Chest | 30.24 | 34.44 | inches |
| Waist | 27.45 | 27.5 | inches |
| Weight | 101 | 130 | pounds |

The stretching up in height is always a noticeable thing at this age but these measurements show not only the height but other spectacular changes. The chest measurements from 30.24 to 34.44 make us reflect again on our physical education program in relation to the cardiovascular system. How much of the heart pathology of later years had its beginning in overdoing a growing heart? Does the increased consumption of caffeine-containing beverages affect the growing heart? It is always well to remember

that the heart does not complete its growth until after the twentieth year.

The figures offer an interesting study for the boys themselves. Taking 23 seconds as the average for complete circulation time in the adult, we may assume for purposes of comparison that it takes 30 seconds for the blood to go to the big toe and back again in an adolescent boy. If the boy is 60 inches tall, the distance from heart to toe is, approximately, 46 inches.

Then if the blood makes two trips to the toe and return in one minute, it means that the heart pumps the blood 4 x 46 or 184 inches (15.38 ft.) in one minute. At 15 ft. for one minute, for an hour, it pumps 60 x 15 or 900 ft. In a day, 24 x 900 ft. or 21,000 ft. which makes nearly four miles! And this is just to the toe alone. The poor old pump must see that there is an adequate supply for the whole body. It is quite a trip to the thumb and back. And how about going to the brain so that our adolescent may keep up with his studies?

After the boy has figured to his bewildering astonishment, let him write down the main body-building foods in one column and in another what he eats in an average day.

After this game of figures, the food that he eats has a new meaning. He isn't an American boy if he doesn't understand fuel and oil.

And we may leave the circulation altogether and find interest in other body changes. A study of Grecian statuary will show him that the body gradually changes with the dietary and other habits of generations and with the mingling of races. The Ancient Greek, as judged by the art of that period, shows a massive torso of strength while our boy shows more slenderness. He is built on a speed model.

The measurements for the girls presented a different problem. The chest measurements were not taken because of the difficulty of getting accuracy with a student monitor. However, in place of the chest, the hips were taken with the greater trochanter as a finding point.

The following figures were found to be the average on 76 B7 girls and 55 A9 girls:

| | *B7* | *A9* | |
|---|---|---|---|
| Standing height | 59.64 | 63.05 | inches |
| Sitting height | 30.76 | 33.73 | inches |
| Waist | 25.68 | 26 | inches |
| Hips | 33.80 | 36.46 | inches |
| Weight | 97.70 | 120 | pounds |

The girls' growth also shows changes in the cardiovascular system but she does not have the mathematical interest to estimate their significance. The boy's growth is objective, the girl's subjective. He feels an exultation over his own increase in strength and he knows of his own virility. The girl knows her change in body contour and developing menstrual cycle. She feels emotions that she does not understand. She wishes to attract as a natural part of her subjective development, therefore her interest in personal adornment.

At this age the girl begins to gush and exclaim over a baby as latent mother instinct asserts itself. Unfortunately the education of the adolescent girl is too much influenced by commercial companies who have something to sell. There is a paucity of education in motherhood particularly at the opportune time of adolescence. We are appalled at the garish make-up of the Junior High School girl and her precocious immodest attempts at sex attraction. But what constructive help are we giving her?

A study of this kind, participated in by the students, yields interesting and instructive facts. It also can be used to teach many health lessons.—Reprinted from *Health Education Journal*, Los Angeles City Schools.

* * * * *

**Fire Drills,**—School officials who are responsible for planning fire exit drill should bear in mind that no school building is completely fireproof, no crowd of children is panic-proof, and no fire exit drill is foolproof, the Federal Security Agency warned today. These principles are basic to a general program of fire exit drill procedures and pupil protection as outlined in "School Fire Drills," a 19-page Office of Education pamphlet released by the Agency.

* * * * *

## MEETINGS

**American School Health Association** and the American Public Health Association, Annual Meeting at Boston, Mass., November 8-11, 1948.

School Health Association Headquarters, Hotel Statler.

New York State School Physicians Association, Saratoga, Springs, July 20, 1948.

## SWIMMING

*Safety Education**

*Statistics,*—1. In recent years drownings have accounted for a third of the public non-transportation accidental deaths and about 5 per cent of all accidental deaths.

2. Children under 15 are the victims in a third or more of these drownings. Most of the children drowned are 5 to 14 years of age.

3. Several hundred of these drownings were of children under three and persons 70 years and over, nearly all of which may be assumed to be nonswimming fatalities.

4. It is likely that drownings while swimming or playing in the water numbered between 4,500 and 4,700.

5. About seven-eighths of the drownings are boys or men.

*Swimming,*—6. It is advisable to have a medical examination before learning to swim. Know and observe your swimming limitations.

7. Do not swim alone and do not swim when you are tired, overheated or chilled.

8. Do not jump or dive into water that may be so cold that it will numb your body. Instead, ease into the water gradually. Cold water exhausts a swimmer more quickly than warm water, therefore, do not swim long distances in cold water.

9. A swimmer may find temporary relief from fatigue by floating or by varying his style of swimming.

10. Cold or tired muscles are susceptible to cramps. To overcome a leg cramp draw your knees up toward your chest, massage and move your cramped foot or leg while you are in "face float" position.

11. For novices, eight feet of water is considered the minimum for all-round diving safety from floats, low platforms and springboards.

12. Never dive in water where there may be large rocks or submerged logs.

13. Avoid swimming in the dark.

14. Never jokingly call for help.

15. When a swimmer is in trouble he should keep calm, keep hands and arms under water, and save breath by not crying out more than necessary. Avoid striking about because this is exhausting. When help arrives, co-operate with rescuers.

*Lifesaving,*—16. Know your capacity for rescuing another swimmer. Whenever possible allow only experienced swimmers to

*Published by the National Safety Council.

attempt personal rescues. If a person is in distress, try to reach him by boat or, if you are near enough, hold something for him to grasp so that he may be pulled in.

17. Swim only when other means of rescue are not possible.

18. Remove shoes and outer clothing before entering water.

19. Enter water feet first. Carry a stick, a shirt or a rope for the distressed person to grasp.

20. Approach from behind the person. If he attempts to hold you, duck your head and push him away or turn him around. Use cross-chest method of towing into shore.

*Breathing,*—21. Breathe through the mouth. The more experienced swimmer can inhale via the mouth and exhale via the nose. If the swimmer plunges or dives into the water, nasal exhalation at the moment of contact with the water is essential. When jumping into the water, pinch nostrils shut either with the fingers or with a nose clamp.

*Ear Protection,*—22. A perforated ear should be plugged with lamb's pool or cotton immersed in oil to keep water out of the ear canal. Commercial plugs are also satisfactory.

*Eye Protection,*—23. If the swimmer fears eye infections and irritations, he should wear a pair of rubber goggles.

*Surfbathing,*—24. Know surf conditions. Swim only on guarded beaches supervised by lifeguards and equipped with life-saving equipment.

25. Always consult the lifeguard about beach conditions.

26. Try not to fall in back-rushing water.

27. To come in on a breaker, begin swimming ahead of it and ride as fast as you can. When momentum is spent, rest easily until next breaker comes, then work in on billows.

28. When the surf beach is smooth and has a rather sharp rise, expect undertow and backwash during last two hours of incoming tide. Avoid beach areas which have even shallow holes because current in such areas can be dangerously fast.

*Beaches,*—29. Safe swimming areas should be marked off by buoyed lines or booms for various classifications of swimmers.

30. A lifeboat is the only craft that should ever be allowed in the swimming area. The outermost limits of the area should be marked by buoys to warn all craft to keep out.

*Unsupervised Bathing Beaches,*—31. Swimming areas should be chosen carefully.

32. If a bather is a nonswimmer, confine bathing to shallow, safe waters. If he is a swimmer, he should swim reasonably close

to shore. Neither swimmers nor nonswimmers should bathe alone; bathe with a partner who can swim, preferably one skilled in lifesaving.

33. Picnic and outing parties should include one or more persons trained in lifesaving, if members intend to do any swimming.

*Organized Bathing Beaches,*—34. The following equipment is standard for an organized bathing beach: lifeboats, surfboards, ring buoys, torpedo buoys and grappling irons in sufficient quantity for all needs. Buoys are not required on *open* surf beaches.

35. If possible, diving and sun deck facilities should be part of the dock structure. Otherwise a float should be anchored off shore, or a diving platform erected on a solidly placed subsurface structure. Lifelines which are attached to the float should never extend inward to the shallow area. Some nonswimmers may try to follow the line hand-over-hand out to the float; if the line sags or they lose hold, they may get into difficulty.

*Swimming Supervision,*—36. Every organized bathing beach or swimming pool should be supervised by well trained men or women able to act intelligently and correctly in an emergency.

37. On large bathing beaches lifeguards should isolate themselves on stands to keep constant watch over bathers. Occasionally, they should patrol the outer limits of the bathing area in a lifeboat. During hours of duty they should not enter the water except to assist swimmers.

38. A lifeguard should insist that all swimmers, no matter how skilled they are, remain within the supervised area. Nonswimmers must be prevented from going into deep water even though they have waterwings or other support.

39. Novice divers should not be permitted to attempt fancy diving stunts for which they are not yet ready. High diving platforms should be used only by competent divers.

40. Play activities on the beach, on docks, on pool decks and in shallow water should be confined to areas which will not endanger either participants or bystanders. Horseplay must not be tolerated.

*Methods of Organization,*—41. Some system for checking bathers in and out of the water should be used in open-air organized beach bathing so that disappearances can be noted quickly. Real safety for group swimming should require competent supervision in the ratio of at least one supervisor to every 10 swimmers.

42. When a group of swimmers is not so large as to make the checking system cumbersome, simply call the roll.

43. A checking-board does away with calling the roll because the bather checks himself in and out of the water.

44. A girl's organization can use a system of colored bathing caps. Non swimmers can wear one color, elementary swimmers another, and swimmers still another.

45. The buddy plan is effective for controlling large or small groups. Pair all bathers in a group according to their respective swimming abilities and make each member of the pair responsible for the other. Buddies are not responsible for rescuing their partners, but they should notify the supervisor or lifeguard.

*Swimming Holes,*—46. The floor of a good swimming hole slopes gently toward deep water; it has no holes, step-offs or hidden obstructions. In standing depth areas, the floor is composed of firm sand, gravel or shale; has no silt, quicksand, shell patches, sharp and broken rocks or debris.

47. Conditions may be improved by removing obstructions or by marking those which cannot be removed.

48. Use chemical tests to determine if water is safe for bathing.

49. Enclose shallow water of swimming area by roping a few logs end to end.

50. One or more trained lifesavers in every swimming hole group is the best safeguard against drowning.

51. Diving boards should be mounted securely in places where water is deep enough for safe diving.

52. A coil of line and one or two poles 10 to 12 feet long should be conveniently placed on the banks where they can be used for rescues.

53. Deep water or poor bottom surface may be overcome by constructing a crib. A beginner's crib is essentially an open-seamed scow which, when placed in water, fills but remains afloat.

*Artificial Pools,*—54. The floor of a good artificial pool inclines gradually toward the deep end or side and is surfaced with smooth cement finish or unglazed tiles. Rough cement will scrape and cut the swimmer's feet, and glazed tiles offers treacherous footing.

55. The safe swimming tank has a deepening shallow end for nonswimmers; the remainder of the pool is for swimmers and divers. The markings "shallow end" or "deep end" and maximum and minimum depths are inset in tile or painted letters and are also indicated in the same way. Water is disinfected and changed often.

56. Shepherd's crooks and poles are standard rescue devices of indoor pools. Large pools and those in the open should have ring buoys and lines.

*Diving Platform Construction,*—57. Diving towers and platforms upon which springboards are erected should be strong and put together with galvanized iron bolts rather than spikes. Constant vibration will loosen timbers and draw nails or spikes. Diving towers and springboards should be erected according to Amateur Athletic Union recommendations.

*Source Material,*—58. Accident Facts. 96 pp. Chicago, Ill.: National Safety Council. 1947. 50 cents.

59. Life Saving and Water Safety. The American Red Cross. Philadelphia, Pa.: P. Blakiston's Sons & Co.

60. School Safety Lesson Outline—June—Safety in Water Sports. New York, N. Y.: Center for Safety Education, New York University, June 1944.

61. Swimming Safely. Louis J. Silvers. *Hygeia.* July 1942.

Other Safety Education data sheets now available are: (1) Bicycles; (2) Firearms; (3) Matches; (4) Toys and Play Equipment; (5) Falls; (6) Cutting Implements; (7) Lifting, Carrying and Lowering; (8) Poisonous Plants; (9) Electric Equipment; (10) Pedestrian Safety; (11) School Buses; (12) Flammable Liquids in the Home; (13) Passenger Safety in Public Carriers; (14) Chemicals; (15) Hand Tools; (16) Non-electric Household Equipment; (17) Sidewalk Vehicles; (18) Camping; (19) Alcohol and Traffic Accidents; (20) Cooking and Illuminating Gas; (21) Solid and Liquid Poisons; (22) Safety in the Gymnasium; (23) Laboratory Glassware; (24) Places of Public Assembly; (25) Fireworks and Blasting Caps; (26) Domestic Animals.

Data Sheets reprinted from Safety Education are available from the National Safety Council, 20 N. Wacker Drive, Chicago 6, Ill., at 5 cents each.

* * * * *

**Diphtheria,**—Seventeen New York upstate municipalities, having a population of 10,000 or more, are on the honor roll. They have immunized at least 70 per cent of their preschool population against diphtheria. According to the records of the State Department of Health these municipalities are:

| | | |
|---|---|---|
| Binghamton | Newburgh | Port Chester |
| Hudson | Niagara Falls | Rochester |
| Irondequoit | Ogdensburg | Syracuse |
| Little Falls | Ossining | Watertown |
| Mamaroneck | Oswego | White Plains |
| Middletown | Peekskill | |

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## EDITORIAL

The School year draws to its close.

It is the time for counting our accomplishments—our successes and our failures. An intensive study of these opens the door to advances.

Is our school health program becoming better coordinated? Is our health education bringing better health examinations? Are these in turn becoming more an education as to the healths needs of each child? Is the parent more interested in the physical and mental improvement of the child? Is this proven by an increased percentage of correction of handicaps? Have we repeatedly put before the Board of Education and the public concise, graphic reports on our program and its accomplishments—and needs?

We repeat here some of the questions asked in an Editorial of the Journal of the American Medical Association (September 20, 1947, page 160):

"Is the time of the physician in the school most profitably spent in routine medical inspections; should physicians continue to cooperate in school medical inspection plans that fall far short of meeting minimal medical standards; is the Astoria plan of school medical advising in every way superior to the older plan of medical inspecting; should all physicians who serve schools have some preservice instruction in school organization and administration; what methods have been found effective for procuring the correction of physical defects found on medical examination; how can the

physical education program be adapted to the varying health needs of the individual children, and how can the health teaching program and the health service program best be coordinated?"

Before plans for the next school year are completed, an earnest effort should be made by Directors of School Health and Superintendents of Schools—and by their advisers and other personnel—to come to decisions regarding these points, and to try to solve them.—*C. H. K.*

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## ABSTRACTS AND NOTES

**Epidemic Ringworm of the Scalp,**—Ringworm of the scalp is becoming increasingly important in the United States and is receiving considerable attention in current journals. As this disease usually occurs only in the pre-adolescent child, the public health nurse doing school work should know the essential points in regard to the disease and also the pitfalls to be avoided in survey and treatment work.

Ringworm of the scalp (tinea capitis) is caused by a fungus, usually Microsporon audouini. This fungus is not known to exist in nature except on the human head, in the hair and hair follicle and occasionally on the skin. Any means by which an infected hair can be brought in contact with an uninfected head may cause an infection. Infected hairs have been found present in barber shop clippers, the backs of movie seats, children's caps, coats, combs and brushes. These all represent possible sources of contamination.

The disease is several times more prevalent in boys than in girls. The posterior occipital area has been the most common site of involvement.

*Surveys*: Surveys of all children should be conducted in grade schools where any cases of ringworm are known to be present. The scalp of each child should be examined under the Wood's Light. Hairs infected with the Microsporum exhibit a bright green fluorescence.

The following equipment is suggested: A Wood's Light, a dark room, cotton balls and alcohol, plain tooth forceps for manual epilation of infected hairs, glass slides between which infected hairs can be placed to send to the laboratory for culture, alcohol lamp or Bunsen burner to sterilize forceps, etc., and adhesive tape to use as "blotting paper" to pick up loose hairs.

The procedure is to have each teacher bring her class to the examining room with a list of the names, ages, sex of children, and columns for recording results in code. The child should be placed in a chair directly in front of the light. It is advisable for

persons working in the vicinity of the light for long periods to wear protective glasses over their eyes. The heads are best examined by using the hands directly. The head should be turned slowly under the light and the hair ruffled so that a clear view of the scalp can be obtained. In girls, the hair should be separated in sections so that the scalp can be observed in 1 to 2 inch areas.

In survey work it is not necessary for the examiner to wash the hands after each head. After a positive head has been examined, the operator should examine her hands and instruments with care under the light to see that no fluorescent particles of hair remain. Any hairs present on the hands or instruments should be carefully removed with a piece of adhesive tape.

Confusion often exists about fluorescent material on the scalp. The disease itself is characteristic and is very rarely missed when present. The infected hairs fluoresce as a bright yellow-green which is instantly diagnostic. However, there are a few conditions which may be wrongly interpreted:

Old cases need to be rubbed with an alcohol sponge to eliminate crusts.

Hair oil and greases also need to be removed by alcohol sponge or thorough washing.

Scar tissue gives a whitish to purplish fluorescence. Chicken pox scabs may be confusing and dandruff, eczema and flakes may give similar fluorescence. Cleansing with alcohol in most cases removes these.

Wool or cotton threads may fluoresce as well as white hairs or areas of congenital lack of pigment.

No attempt should be made to diagnose ringworm of the glabrous skin by means of the light.

It is advisable to conduct two additional surveys at monthly intervals after the initial one and then re-survey every three months.

*Treatment*: It is best to advise all concerned that the disease is tenacious, the treatment is long and often discouraging. If an ideal treatment were available for this disease, it would have a two-fold action (1) to remove the infected hair completely from the head and (2) to penetrate and destroy the fungus on the hair shaft and in the follicle. Unfortunately no known method of treatment accomplishes both of these simultaneously.

It is generally agreed that X-ray epilation, followed by topical fungicidal medication offers the most rapid and effective method of cure. However, this method has many drawbacks: it is expensive and is not available in many communities; it occasionally causes

permanent alopecia and the X-ray has no effect on the fungus growth itself. Its sole purpose is to remove the hairs from the follicles and a fungicide medication must be applied in order to destroy the spores in the follicles.

The treatment by topical medication is far from ideal, but it is of necessity the method most generally in use in epidemic areas, especially where no facilities for X-ray epilation are available. Schwartz reported 98 per cent cured in nine months. Other authors have reported various findings from 9 to 12 per cent, up to 40 per cent. Studies in North Carolina showed 30 per cent cured in five months (unpublished). Because the ideal drug is not known, many different preparations remain in general use. The basic principles of a treatment program sponsored by the Health Department have been outlined in the U. S. Public Health Service's Public Health Bulletin No. 294, "Control of Ringworm of the Scalp Among School Children, Hagerstown, Maryland, 1944-45." In brief these are:

1. No infected child should be allowed to attend school without wearing a cap. A stocking cap is recommended and should be changed daily.
2. The hair must be clipped at intervals to beyond the area of infection.
3. The head should be washed daily.
4. The mother should be instructed to epilate with tweezers all hairs in the infected area. This is probably the most important factor in the rapidity of cure.
5. Great care should be taken within the family to prevent spread of the disease.

Suggestions regarding equipment and procedures for giving treatments in a school clinic include a suitable room, instruments, Wood's Light, records, etc. The children should have a stated time to come to the clinic daily and each should have at least 45 treatments. It is advisable to circle with mercurochrome under the light the areas to be clipped and treated. The nurse will accelerate treatment by epilating with forceps all positive hairs, especially areas which the parent might not do.

When it is not possible to conduct daily treatment in school, arrangements should be made for follow-up in observation clinics.

Careful evaluation should be made of progress in each case and the following criterion is suggested to determine "cures":

When a child shows no further fluorescence, and the culture report is negative, the child is dismissed from treatment. However, he is followed weekly with the light examination for four weeks, and again at the end of the next month. Thus ten weeks

elapse after the child is first found to have no fluorescence before he is termed "cured".

Complications such as secondary infection sometimes do occur and may be quite severe, calling for a modification of the method of treatment and special treatment for the infection. The ringworm tends to subside more rapidly in some of these cases. Abstract of article by Mildred A. Morehead, M.D., Journal of Public Health Nursing, Vol. 40, No. 4, for April, 1948, page 186. Abstracted by Dr. Wm. E. Ayling, School Health Director, Syracuse, N. Y.

* * * * *

**Rural Health,**—At the National Conference on Rural Health held in February, 1948, in Chicago, three papers were presented on the study of Child Health Services. Dr. John Hubbard, Director of Child Health Studies, American Academy of Pediatrics, Washington, D. C., presented a paper which the Journal of the A. M. A. will publish in the fall. Dr. Katherine Bain, Director of the Division of Research in Child Development, United States Children's Bureau, Washington, D. C., pointed out that economists say that children in the city have and children in the country have not. This is not altogether true of medical care since people seek medical care where they can get it. Persons in rural areas adjacent to cities have more chance of getting adequate medical care than those in the outlying country.

Dr. Bain calls attention to the National Survey of 1935 in which a personal interview with a sample of the population was held. The study gathered data from the persons rendering service, from the physician, hospital, clinic, etc. It was found that a thousand children in Illinois or in Maryland and the District of Columbia have on an average day twice as much medical care as a thousand children in Alabama. Dr. Bain asks, "Are the children in Alabama less in need of medical care?" She doubts it. They likely get not more than half as much care as they actually need. Children in or near cities get more medical care than children in the outlying district. In addition to more in quantity, there is also more in quality. Children near cities have twice as much hospital care, five times as much clinic care and four times as many visits to the pediatrician.

Dr. Bain shows what maldistribution is in terms of the amount of medical care. She asks what this means in terms of health for children and what is the end result. She points out that infant mortality for the five years of 1941-1945 was 38 for the metropolitan area and 47 for the isolated county area. Infant mortality rate has long been considered a delicate index of the health of a community.

Dr. Henry Poncher, American Academy of Pediatrics, calls attention to the need for improvement in the medical care and health supervision of children. He points out that the mental health of adults depends on the care they received as children. While improved physical facilities are important, the judgment and the skill of the individual physician in matters pertaining to the child's health is paramount.

Dr. Poncher points out that the general practitioner provides 75 per cent of the medical care for children and most of these physicians have had very little hospital training in pediatrics. Under graduate and graduate courses must provide for the general practitioner pediatric training. Pediatric education must, therefore, be improved and made available to more persons who will go to the rural areas. Rural communities should take the initiative in asking for improved medical facilities.

Dr. Lee Forrest Hill of Des Moines, Iowa, discussed Health Problems of the Rural Child. He called attention to the fact that no standard has been set up defining the kind and amount of medical care that a child should receive whether the child lives in the city or in the country.

Dr. Hill notes that the pediatricians of the nation are located almost exclusively in the larger cities. Most of the children in the United States are, therefore, dependent on General Practitioners for supervision of their health. While Dr. Hill feels that these men are doing a good job, he also feels that it would be well for the General Practitioner of the future to have more training in pediatrics.

Preventative services are notably lacking in rural communities. Since pediatricians are largely engaged in health supervision of well children, rural communities do not have these advantages. Careful examinations with laboratory tests and immunization procedures with one or both parents present is the kind of preventative work which needs to be done if children are to develop healthfully in the emotional as well as the physical aspects of their lives.

To expect the busy rural practitioner to do these things is out of the question. He does not have available specialists to consult nor does he have other essential facilities like hospitals and laboratories. Dr. Hill suggests that pediatric hospitals can be of great help by rotating some of their resident staff through smaller rural hospitals weekly or semi-monthly. The rural General Practitioner would be greatly helped in these clinics and in turn the rural child.

One half of the deaths in the neonatal period occur among

prematurely born infants. If special facilities were available and personnel, many of these infants could be saved.

Summarizing Dr. Hill says: "More physicians in rural communities, increased emphasis on pediatric teaching in medical education, pediatric internships, rotation of pediatric residents from approved hospitals in rural hospitals, frequent visits by consultants, more post graduate education in pediatrics, more adequate school health services by trained physicians, public health services including nurses in all rural communities, and the establishment of premature stations wherever needed."

* * * * *

**Brain Injury From High School Boxing,**—To the Editor: Discuss the hazard of boxing wherein the individual gets repeated blows on the head especially if continued over long periods of time. May this punishment result in mental impairment? What is the literature covering this subject.—H. F. Schroeder, M.D., Marinette, Wis.

*Answer.*—A great number of physicians and physical educators have become convinced that boxing cannot be defended as an appropriate sports activity for high school boys.

A. H. Steinhaus (Statement on Boxing in High Schools, J. Health & Phys. Ed. 15:384, 1944) in reviewing the data on this subject, asserts that present knowledge appears to warrant acceptance of the following statements:

1. Any serious head injury even without skull fracture or knockout may be accompanied by pinpoint hemorrhage or other brain injury.
2. Such injuries may be suffered equally by experienced or inexperienced boxers in their first encounter or after long experience.
3. There are many portions of the brain in which destruction of a small amount of nerve tissue does not cause paralysis or other noticeable changes in behavior. This is especially true in certain subcortical centers . . . and of the cortex where the highest human faculties such as delicate coordination, memory, speech, self control and the power of reasoning are lodged. Subsequent injuries add to earlier ones, since each is permanent. The exact location and extent of each injury and the total of all injuries will determine the extent of loss of mental powers or bodily control.

A great deal of the strength and endurance which has been attributed to boxing comes about as a result of the training program in which the boxer takes part. These activities can be a part of the preparation for participation in other sports or of a broad program of physical education. In boxing, the primary target is the head, and the goal is to injury or physically punish the opponent with the knockout as the eventuality. This is at variance with sports in which injury is incidental, as for example in football where the touchdown is the goal and the injury only a possible by-product.

E. J. Carroll (Punch Drunk, *Am. J. M. Sc.* 191:706, 1936) after two years' study of boxers to develop a medical understanding of the problem concluded: "It is probable that no head blow is taken with impunity and that each knockout causes definite and irreparable damage."

Stating that the incidence of mental injury among those who have stayed in boxing long enough is nearly 50 per cent, H. S. Martland (Punch Drunk, *J. A. M. A.* 91:1103, 1928) added that "this seems to be good evidence that some special brain injury due to their occupation exists."

Ernst Jokl in his book on "The Medical Aspects of Boxing" (Pretoria, South Africa, J. L. Van Scaik, Ltd., 1941) says that "there is no evidence to support the frequent allegation that boxing is a particularly valuable method of developing character, determination, and personality . . . that the refusal to realize the danger of boxing is responsible for many a boxer's life being spoiled; that boxing often exerts a brutalizing influence on spectators and that it appeals to the lowest human instincts."

Kenney, Thacker, and Gebhart (The Evaluation of Boxing as a College Activity, *Research Quart,* 11:80, 1940) polled opinion of health service directors in some sixty colleges and universities. Only 15 per cent considered boxing an appropriate high school activity, and slightly more than 50 per cent did not favor the sport for intercollegiate competition.

Proponents of "controlled" boxing for high school boys argue that with heavy gloves, adequate protection and close supervision the activity differs sharply from prize fighting.

However, Steinhaus in the article previously cited raises the following questions in respect to this reasoning and suggests that a single answer *"no"* invalidates boxing as a high school activity:

1. Can the full advantages distinctively credited to boxing be attained short of genuine "all out" boxing?
2. Can the average high school coach or teacher control a large class of boxers to insure safe boxing?
3. Is there available and on hand a thoroughly safe head gear to protect not against head injury, but brain injury?
4. Is the average boy who becomes good in the sport willing to use his skill only in self defense and unlikely to use the sport as an offense in overcoming opponents both in and out of athletic contests?
5. Can a high school teach boxing without at once giving implied approval to amateur boxing tournaments and to the professional ring?

To protect the welfare of high schools boys participating in interscholastic activities the Legislative Council of the American Association for Health, Physical Education and Recreation adopted the following resolution (on file in the office of the executive secretary of the American Association for Health, Physical Education

and Recreation, Washington, D. C.) in April 1940:

WHEREAS, There seems to be an increasing tendency to promote interscholastic boxing in some communities and on the part of some individuals, and

WHEREAS, Boxing on a highly competitive basis is known to be potentially dangerous to the safety and welfare of boys participating; be it therefore

*Resolved*, That the American Association for Health, Physical Education and Recreation recommends the discontinuance of interscholastic boxing for boys 18 years of age or younger; and be it further

*Resolved*, That this Association shall encourage all school administrators to immediately take steps to eliminate boxing from their interscholastic athletic programs. (From *Journal*, A. M. A., March 2, 1948, p. 907).

* * * * *

**School Health Service Recommendations,**—The Conference on the Cooperation of the Physicians in the School Health and Physical Education Program held in Highland Park, Ill., Oct. 16-18, 1947, resulted in the following recommendations of interest to all physicians concerned with school health work:

1. In order that a school health program may be kept continuously in proper relationship with public health services, welfare services, medical and dental services and all the health resources of the community, it is essential that some form of community health council, bringing together representatives of all local groups with definite health responsibilities, be formed.

2. Wherever there is a school, the local community should budget for a school health program in the department of education, in the department of health or in both. In that budget there should be adequate provision for the salary of a well qualified medical adviser serving the school full time or part time as the need requires.

3. Every school system should have an advisory school health council, exery school a health committee, every local medical society a school health committee. In some instances such committees or council can best be developed within the framework of an already existing plan of organization.

4. The physician's time in the school can best be utilized (a) if he is employed as school medical adviser rather than as school medical inspector; (b) if the routine medical examinations, whether done by the family physician or the school physician, are spaced at three year intervals during the school life of the child; (c) if pupils in need of special examination and advice are carefully selected by the teacher and made the subject of a physician-teacher conference, and (d) if considerable portions of the routine examinations are delegated to teachers and nurses, reserving for the physician only those portions which he alone is equipped to do.

5. Since immunization is necessary for protection particularly

in the infancy and preschool period, the schools should definitely discourage the practice of postponing inoculation to the period of school entrance.

6. It is essential that teachers be aware of the physical handicaps of their pupils. Results of medical examinations of her pupils should therefore be interpreted to the teacher in the physician-teacher conference, making certain that the teacher thoroughly appreciates the importance of safeguarding all matters of a confidential nature.

7. Instruction as to the need and value of voluntary planning for medical, dental and hospital expenses through prepaid programs should be stressed in the high school curriculum.

8. Cumulative health records should be a part of the child's total school record throughout his school life.

9. In determining the content of the physical education program the physical education teacher, the physician and the pupils should all play an appropriate part.

10. Physicians and physical education teachers in the various communities should arrange joint meetings for the discussion of such problems as the individual-adapted physican education program and the classification of pupils for physical education activities.

11. In those communities where graded types of physical education activities adapted to the varying needs of pupils are available in the school, permanent and blanket excuses from physical education should rarely if ever be given.

12. All school health service personnel should have experience in field work as a part of their preservice training.

13. Medical schools should give additional training to medical students in regard to (a) the relation of the physician to the school and to the community; (b) the physiology of exercise and the function of physical education in the life of the child; (c) the pediatric examination as the model for school examinations, and (d) how the school physician may function as a medical adviser rather than a mere medical inspector.

14. Schools of public health should give increased emphasis in their training of health educators, physicians and nurses to (a) school health, (b) the basic philosophy of general education, and (c) school organization and administration.

15. In every community there should be planning and inservice training conferences, institutes and workshops involving teachers, physicians, nurses, dentists, dental hygienists and others interested

in the community health program to work out problems related to that community.

16. There is urgent need for research into many phases of school health service and particular need for evaluation of procedures not only in terms of defects found and remedied but also in terms of educational outcomes in the child, increased understanding of the child by the teacher and increased provision of special programs of education for the exceptional child.

17. A joint committee composed of representatives named by the American Medical Association and the American Association for Health, Physical Education and Recreation (perhaps as a subcommittee of the Joint Committee on Health Problems in Education of the National Education Association and American Medical Association) should be appointed to draw up recommendations regarding (a) the administration of the individual-adapted program of physical education, (b) the medical examination and guidance of athletes.*

18. Authoritative committees already functioning should be asked or new committees should be formed to study (a) posture, (b) the effects of vigorous physical activities on the cardiovascular system, (c) psychologic attitudes of participants toward physical education activities and (d) energy expenditure in the various types of physical activities.

19. State medical societies and associations should be urged to plan jointly with their health department, education department and education association for the development of conferences at the state level which are comparable to this conference at the national level. It is suggested that the needs of rural schools should receive special consideration.

NOTE: The full report of the Conference is in the process of printing and will be available shortly at a nominal charge from the Order Department of the Association. From Journ. A.M.A., Nov. 22, 1947. pp. 778-779.

*Since the American School Health Association, has as its major objective the better organization and functioning of the whole school health program, it is suggested that this American School Health Association also should be represented on such a joint committee.—Ed.

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## PROGRAM — ANNUAL MEETINGS

## NEW YORK STATE ASSOCIATION OF SCHOOL PHYSICIANS AND NEW YORK STATE SCHOOL NURSE TEACHERS ASSOCIATION

### TUESDAY, JULY 20, 1948

**9:00 A.M.** EXECUTIVE COMMITTEE, New York State Association of School Physicians

**10:00 A.M.** ANNUAL MEETING, New York State Association of School Physicians

**10:00 A.M.** BUSINESS MEETING, New York State School Nurse Teachers Association

**12:00 M.** **LUNCHEON—School Nurse Teachers**

Speaker: DR. DANIEL R. HODGDON, Hofstra College

*"The School Health Service and the Law"*

**1:00 P.M. to 5:00 P.M.** **GENERAL REGISTRATION—Drawing Room**

**2:00 P.M.** **GENERAL SESSION**

Presiding: DR. HARRY V. GILSON, Associate Commissioner of Education
New York State Education Department

*Presidential Address*: DR. C. ADELE BROWN, Oswego, N. Y.

*The Rehabilitation of Moderately Severe Behavior Disorders and Psychoneurosis in School Children*

"The Part of the Psychiatrist"

DR. EDD CLARDY, Director of the Children's Group
Rockland Memorial Hospital, Orangeburg, New York

"The Part of the Schools"

SAMUEL HICKS, Superintendent of Schools,
Pearl River, New York

Discussion opened by DR. ISAAC SHAPIRO, Associate Professor of Neurology, Albany Medical College

**8:00 P.M.** **GENERAL SESSION (Ballroom?)**

Presiding: DR. C. ADELE BROWN, Oswego, New York

*What's New in the State Education Department*

DR. LILLIAN DeARMIT
Division of Health and Physical Education
New York State Education Department

*The Changing Conception of the Educational Care of the Handicapped Child*

DR. VIVIAN ELLIS
Bureau of Physically Handicapped Children
New York State Education Department

*The Epileptic Child and the School*

DR. JERRY C. PRICE
Neruological Institute, New York City

Discussion opened by PRINCIPAL ROBERT MURRY,
Pleasant Valley School, Schenectady, N. Y.